



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HOUSTON METHODIST HOSPITAL

Respondent Name

AMERICAN GUARANTEE & LIABILITY

MFDR Tracking Number

M4-15-3592-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JUNE 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the Hospital Facility Fee Guideline."

Amount in Dispute: \$24,743.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The initial bill was received per the date stamp on 1/30/15. The reconsideration bill on 4/15/15. Under Sec. 408.027(a), health care provider (HCP) have 95 days from the date of service to submit a medical bill to the insurance carrier."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|------------------------------|-------------------|------------|
| July 1, 2014 through July 2, 2014 | Outpatient Hospital Services | \$24,743.67 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.

4. The services in dispute were reduced / denied by the respondent with the following reason codes:
- 246-This non-payable code is for required reporting only.
 - 29-The time limit for filing has expired.
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.
 - 5-The procedure code/bill type is inconsistent with the place of service.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - Code 27535 is inpatient service, not paid as out patient service allowance change.

Issues

Did the requestor support position that the disputed bills were submitted timely?

Findings

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29."

Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

The respondent states "The initial bill was received per the date stamp on 1/30/15. The reconsideration bill on 4/15/15. Under Sec. 408.027(a), health care provider (HCP) have 95 days from the date of service to submit a medical bill to the insurance carrier."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the submitted documentation does not contain any evidence such as a fax, personal delivery, electronic transmission, or certified green cards to support the bill was sent to the respondent.

The Division finds that the requestor did not submit any documentation to support that the disputed bills were submitted timely in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

07/29/2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.